Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature

Review and Evaluation of
LD 1087, an Act to Require All Health Insurers
to Cover the Cost of Hearing Aids

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 1087, an Act to Require All Health Insurers to Cover the Costs of Hearing Aids. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 258. This review was a collaborative effort of Mercer Risk, Finance & Insurance Consulting, Inc. (Mercer) and the Maine Bureau of Insurance (Bureau).

LD 1087 would amend sections of Maine Law pertaining to *all* health policies (including group policies, individual policies and HMO policies). The bill would require:

- All health plans must provide coverage for the purchase of a hearing aid from an audiologist or hearing aid dealer for a person whose hearing loss has been documented by a physician or audiologist.
- "Hearing aids" are defined as any nonexperimental, wearable instrument or device designed for the ear for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devises including but not limited to frequency modulation systems.

The language of the proposed bill, LD 1087, refers to the coverage of "a hearing aid" however the Committee has informed the Department that the intent of the bill is to cover a hearing aid in each ear, if so required. We have performed this analysis to incorporate this clarification.

The Committee has requested that the financial analysis include the following possible amendments:

- the addition of a monetary limit of $1,400 per hearing aid and requiring coverage for 2 hearing aids every 36 months, and
- hearing aid coverage will only be required for children. Children are defined as individuals under the age of 21.

Most carriers surveyed are concerned with the cost impact of mandated benefits. While a specific benefit may only add a negligible amount to the cost of the health insurance policy, the cumulative cost of many benefits can be significant. At this time, health insurers are concerned with the affordability of their products for all citizens. Most of the carriers stated that if the benefit is passed they recommend a dollar limit and frequency limit be passed as well.

We received information regarding existing coverage for hearing aids from Anthem Blue

Cross Blue Shield (Anthem), CIGNA, Harvard Pilgrim, Fortis Life Insurance, United Healthcare Insurance Company (UHIC) and John Alden, the major medical insurers in Maine. None of these insurers provide coverage for hearing aids. In fact, only one company commented that it would provide hearing aid coverage as an option, if requested by a large employer group.

The number of Maine citizens impacted by this bill is very small, only 0.69% of the population would be expected to use this benefit. The average lifespan of a hearing aid is 4 years, therefore in any given year, approximately 0.17% of Maine residents would utilize this benefit. If the benefit were amended to only cover children, only 0.17% of the population would be expected to utilize this benefit. If we assume the average lifespan of a hearing aid for children is 2 years, in any given year approximately 0.09% of the population would utilize this benefit.

The cost for a hearing aid is hard to state generally. It depends very much on the type of model and technology required. The costs can range from $400 to $7,200. The average cost currently expended is estimated to be approximately $3,000 per hearing aid.

Mercer estimates maximum premium increases attributable to enactment of the proposed mandate in aggregate would be 1.2% if the benefit is unlimited. The impact for any particular group would depend upon its current benefit. Small groups and individuals would see an increase of about 1.1%, because typically these groups do not provide retiree health coverage. Large groups would see an increase similar to that of the overall population of 1.3% since they would more than likely provide retiree health benefits. CIGNA estimates the cost to vary between 0.20% and 0.37% of premium. UHIC estimates the costs to be about 1% of premium and Harvard Pilgrim estimates the costs to be between 0.5% and 1% of premium. Anthem estimates the premiums to increase between 1.5% and 3.9%. Anthem's estimate of the number of adults utilizing hearing aids is significantly higher than Mercer's estimate which accounts for the higher percentage of premium.

If the mandate was amended to only apply to children, the cost impact is much less. Mercer estimates the maximum premium increases to be approximately 0.4% of premium. Anthem estimates the increased costs to be within a range of 0.1% to 0.2% of premium. CIGNA's estimates range from 0.06% to 0.13%. UHIC predicts the premiums to increase by 0.7% and Harvard Pilgrim estimates the costs to increase by 0.1%.

If the mandated benefit was amended to limit the benefit to $1,400 per hearing aid with only 2 hearing aids allowed every 36 months, the costs also significantly decrease.

Mercer estimates the maximum premium increases to be approximately 0.3%. Anthem estimated the costs would increase by 1.1% and 2.9%. This is higher than the Mercer estimate, however as stated previously, Anthem uses a significantly higher estimate of adult users than Mercer. CIGNA's range is 0.09% to 0.18%. UHIC estimates the premium to increase by approximately 0.5% and Harvard Pilgrim estimates the cost increase to be about 0.2%.

If both amendments to the proposed legislation were implemented, Mercer estimates the costs to increase by approximately 0.1%.

Self-funded plans would not have to comply with LD 1087 and therefore would not experience an increase in costs.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 1087, an Act to Require All Health Insurers to Cover the Costs of Hearing Aids. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 258. This review was a collaborative effort of Mercer Risk, Finance & Insurance Consulting, Inc. (Mercer) and the Maine Bureau of Insurance (Bureau).

LD 1087 would amend sections of Maine Law pertaining to all health policies (including group policies, individual policies and HMO policies). The bill would require that:

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- "Hearing aids" are defined as any nonexperimental, wearable instrument or device designed for the ear for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devises including but not limited to frequency modulation systems.

The language of the proposed bill, LD 1087, refers to the coverage of "a hearing aid" however the Committee has informed the Department that the intent of the bill is to cover a hearing aid in each ear, if so required. This clarification has been incorporated in the analysis.

The Committee has requested that the financial analysis include the following possible amendments:

- the addition of a monetary limit of $1,400 per hearing aid and requiring coverage for 2 hearing aids every 36 months, and
- hearing aid coverage will only be required for children. Children are defined as individuals under the age of 21.

The current insurance law in Maine does not have any specific requirements for the coverage of hearing aid devices. The survey performed by the Bureau of Insurance shows the major health insurance carriers in Maine do not provide hearing aid coverage in their policies. In fact, only one stated they would offer it on an optional basis to large employers who requested that type of coverage.

At the present time, Medicare does not provide hearing aid coverage to their beneficiaries. The Medicare population has a significant need for this type of benefit. It is estimated between 22 and 28 million Americans have a hearing loss. These statistics include both the deaf and the hard of hearing. Approximately 3 million Americans are considered deaf, leaving between 19 and 25 million that are hard of hearing.[1] About 37% of those people with a hearing loss are 65 years of age or older, or in other words, between 7 and 9 million seniors experience a hearing loss.[2] In 2001, the number of Americans over the age of 65 was estimated to be 35.3 million therefore approximately 20% to 26% of this population are affected by hearing loss and could potentially use this benefit if Medicare would provide it.[3] However, Medicare has opted not to provide this benefit even though a significant portion of their beneficiaries could use it. Rather, they require their beneficiaries to purchase the equipment themselves. Many Medicare beneficiaries have private Medicare supplement plans. There are ten standardized benefit plans pursuant to federal law. None of these plans cover hearing aids and any state mandate would not apply to these plans due to federal preemption. However, some Medicare beneficiaries are covered by employer plans, either as active employees or retirees. These plans would be subject to a state mandate unless they were self-insured plans. A survey of Medicare beneficiaries indicates that approximately 28% of Medicare beneficiaries are covered by group insurance which would be impacted by LD 1087.[4]

MaineCare, the State's Medicaid program, provides coverage for hearing aid devices, although on a limited basis. The program provides hearing aid devices for children up to age 21. The initial trial period requires the purchase of one hearing aid. In addition, there is limited coverage of hearing aids for MaineCare recipients in nursing facilities.

There are other various agencies and foundations that offer financial assistance for the purchase of hearing aids to those individuals that are unable to afford them. These organizations provide assistance to both children and adults. Organizations that provide assistance to children include: Dorothy Ames Trust Fund, Howard & Espa Michaud Charitable Trust and Miracle-Ear Children's Foundation. Organizations that provide

[1] What You Need to Know About Deafness/Hard of Hearing website, "Demographics of Hearing Loss-Statistics on Deafness", http://deafness.about.com
[2] Desai, Mayur, Pratt, Laura, Lentzner, Harold, Robinson, Kristen, "Trends in Vision and Hearing Among Older Americans", Centers for Disease Control and Prevention, March 2001
[3] US Census Bureau, "Table DP-1 Profile of General Demographic Characteristics of the United States"; published May 15, 2001
[4] Kaiser/Commonwealth, "1997 Survey of Medicare Beneficiaries", www.cmwf.org

assistance to adults include: Alpha One, HEAR NOW, Lion's Club and Maine Vocational Rehab program.

There are six states, Connecticut, Kentucky, Louisiana, Maryland, Missouri and Oklahoma, which have adopted laws requiring private health insurance polices to cover hearing aids. At the present time only one state requires private health insurance policies to cover hearing aid devices for adults. The remaining five states provide a mandate for the coverage of children only. Rhode Island passed legislation that requires health insurers to at least offer coverage for hearing aids.

The Connecticut law requires individual and group health insurance policies to provide coverage for hearing aids to children up to age 12. The law allows policies to limit the benefit to $1,000 every 24 months.[5]

The Kentucky mandated benefit requires health plans to cover the cost of a hearing aid for each ear. The benefit amount is capped at $1,400 per hearing aid every 36 months. Hearing aids must be prescribed and then dispensed by a licensed audiologist or hearing instrument specialist.[6] Coverage is required for both children and adults.

The law passed in Louisiana is similar to the one in Kentucky, however coverage is limited to children under the age of 18.

Maryland law provides coverage for minors. The benefit can be limited to $1,400 per hearing aid every 36 months. A study was completed that analyzed the cost impact of these benefits. In that study the impact was estimated to be a 0.1% increase in the premium levels.

The Missouri mandated benefit requires health insurance companies to cover infant hearing screening, audiological assessment and follow-up and the initial amplification, including hearing aids.

The Oklahoma mandated benefit requires group health insurance companies to provide audiological services and hearing aids for children up to age 18. The law requires a prescription for a hearing aid and that it be dispensed by a licensed audiologist. There is

[5] American Speech Language Hearing Association, "State Insurance Mandates for Hearing Aids", www.professional.asha.org/resources/legislative/ha_reimbursement.cfm
[6] American Speech Language Hearing Association

a hearing aid benefit every 48 months without a dollar limit.[7] At the present time the Oklahoma Insurance Department has no information regarding the costs associated with the mandate.[8]

Rhode Island requires health insurance plans to offer the option of purchasing a hearing aid rider with every health insurance contract. The amount of the benefit is left to insurer discretion.[9] To date, there is no information available on the costs associated with the optional coverage or the extent to which employers have purchased the optional hearing aid coverage.

The trend for most states passing hearing aid mandates is to cover the cost for children only. Of these six states that mandate coverage for hearing aids, only one provides coverage for adults. In addition, more than half of these states place an upper limit on the hearing aid benefit in the form of dollar limits and time frames. All of these limits, age, dollars and time frames are similar to those in the proposed amendments to this bill.

[7] American Speech Language Hearing Association
[8] OLR Research Report, "Coverage for Hearing Aids", December 22, 2000, www.cga.state.ct.us/2000/rpt/olr/htm/2000-r-1191.htm
[9] "A Partial Listing of Hearing Aid Insurance Coverage in the United States, 2000", www.hearingloss.org/html/partial752a.html

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

This benefit would be used by a very small portion of the population as the number of persons requiring hearing aids is small and a significant portion of those that do require hearing aids are over the age of 65. Individuals over age 65 would not be impacted by this legislation, with the exception of those covered by employer group insurance. Our analysis incorporates these individuals.

It is estimated that just over 100,000 residents of Maine are deaf or hard of hearing. Of that amount about 90,000 residents are considered hard of hearing.[10] National statistics show that approximately 37% of all hearing impaired individuals are over age 65.[11] Applying this statistic to the Maine population produces approximately 56,700 residents under age 65 and 33,300 over age 65 that are considered hard of hearing. Of the general population under age 65, only 62% have health insurance that would be subject to the requirements of LD 1087.[12] Of those individuals age 65 or older, approximately 28% have insurance coverage that would be impacted by LD 1087.[13] Therefore the total population potentially affected by LD 1087 would be 44,478 or approximately 3.4% of the population.

There are many different estimates for the estimated use of hearing aids among the hard of hearing. These estimates range from 10% to 65% usage depending upon the age of the individual. Using the nationwide prevalence distribution produces an estimate of 20% of the hard of hearing who actually use hearing aids. Applying this percentage to the Maine residents affected by this legislation generates about 0.69% of the population who would use the benefits mandated

[10] Maine Department of Behavioral and Developmental Services
[11] Desai, Mayor, et al.
[12] Henry J. Kaiser Family Foundation website, State Health Facts Online, Maine: Population Distribution by Insurance Status, state data 2000-2001, US 2001
[13] Kaiser/Commonwealth

from LD 1087.

Typically the expected life of a hearing aid is 3 to 5 years.[14] Assuming the average lifespan is 4 years, the mandate will impact about 0.17% of the residents annually.

If LD 1087 is amended to apply only to children, it will affect an even smaller percentage of Maine residents. National statistics show that only 1.7% of children are affected by a hearing loss.[15] Assuming Maine is similar to national statistics, the number of children in Maine that are hard of hearing is approximately 0.4% of the Maine population. Of the general population, only 62% are covered by insurance that would be impacted by LD 1087. As such, about 0.3% of the population in Maine would be impacted by this mandate.

Not all children with hearing problems use hearing aid devices. A study by the Gallaudet Research Institute's Regional and National Summary of Data from the 2001-2002 Annual Survey of Deaf and Hard of Hearing Children and Youth, showed that 63% of children with hearing loss use hearing aids. Therefore only 0.2% of the Maine population would be expected to be impacted by this legislation.

The lifespan of hearing aids for children is less than the 4 year average quoted above. As the child grows older, they are able to respond to more sophisticated tests and the hearing aids can be adjusted accordingly. In addition, as the child grows, the ear grows as well. Therefore frequent and regularly scheduled changes of ear molds must be performed.[16] Assuming the average lifespan of a hearing aid for children is 2 years, the estimated percentage of Maine residents utilizing the mandate annually would be 0.09% of the population.

2. *The extent to which the service or treatment is available to the population.*

Hearing aids are readily available locally as well as nationally.

3. *The extent to which insurance coverage for this treatment is already available.*

[14] Detroit Free Press website, "Consumer Guide: Hearing aids", May 26, 2002
[15] NIDCD website, www.nidcd.nih.gov/health/hearing/hearingaid.asp
[16] American Speech Language Hearing Association website, "Children and Hearing Aids", www.asha.org

Most insurance companies do not provide coverage for hearing aid devices. The Bureau of Insurance surveyed health insurers in Maine. None of the carriers that responded typically provide this type of coverage. Specifically, Aetna, Anthem, Fortis Insurance Company, Harvard Pilgrim, John Alden Life Insurance Company and UHIC specifically exclude coverage for hearing aid devices. UHIC stated that hearing aid coverage was only provided to large groups that requested this coverage be added.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

There are a variety of reasons why people have chosen not to utilize hearing aid devices. Reasons range from discomfort in wearing the hearing aid to social stigmas of feeling "old" to the costs associated with hearing aids. For some of these cases, the availability of coverage will not affect the usage of hearing aids. For those where the cost of hearing aids is a barrier to the purchase, the insurance coverage will generally help. An informal survey regarding insurance coverage of hearing aids conducted by the Listen Up organization found 11% of adults and 1% of children with hearing loss do not use hearing aids due to the cost associated.

Even though most insurance companies do not provide coverage for hearing aids, there are alternative sources available. However, potential coverage from these sources is on a limited basis which has eligibility requirements. The alternative sources are described below.

MaineCare, the State's Medicaid program, provides coverage for hearing aid devices, although on a limited basis. The program provides hearing aid devices for children up to age 19. The initial trial period requires the purchase of one hearing aid. MaineCare will reimburse up to $400 per hearing aid.[17] In addition, there is limited coverage of hearing aids for MaineCare recipients in nursing facilities.

The Veterans Health Administration (VHA) provides hearing aids, among other

[17] Maine Newborn Hearing Program Genetics Program Division of Family Health Bureau of Health Department of

devices, to those veterans who are eligible. All World War I veterans are eligible to receive free hearing aids. Other veterans can receive hearing aid benefits on a limited basis. Eligibility is determined according to priority groups ranging from 1 through 7, with 1 having the highest priority (e.g., veterans with service-connected disabilities rated 50% or more disabling). Other priorities such as levels 2 and 3, can be eligible if the individual meets other criteria.[18]

Another potential source of funding is the Maine Vocational Rehab (VR) Program. This program will provide hearing aid devices if hearing loss is a barrier to employment. For the last two years, the VR program had an annual average of about 300 authorizations. The authorizations include the purchase of hearing aids, repairs for hearing aids, ear molds and batteries.

The Child Development Service System administers the Hearing Impaired Children's Fund. Each year $75,000 is available in the state for the purchase of hearing aids. These funds are depleted annually.

There are several organizations that provide financial assistance for individuals and families that cannot afford hearing aid devices. One such example is HEAR NOW. This organization maintains a National Hearing Aid Bank, which provides new and reconditioned hearing aids to deaf and hard of hearing people who cannot afford them. This organization distributes hearing aids through local providers. It is an organization of last resort.

The Regional Hearing Aid Bank provides free hearing aids to low-income residents in Maine. This is an important resource since MaineCare does not provide coverage to adults over age 19.

In addition there are several national organizations that may be resources for Maine residents. These organizations include but are not limited to: Alpha One, Hear USA Foundation and Hearing Aid Bank, Travelers Protective Association Scholarship Trust For the Deaf and Near-Deaf, Better Hearing Institute, Starkey Hearing Foundation, Easter Seals, Children of the Silent World, Disabled Children's Relief Fund, HIKE Fund, Inc., Unitron's Kids Klub Foundation,

Human Services

[18] Department of Veteran Affairs, Prescribing Hearing Aids and Eyeglasses, VHA Directive 2002-039, July 5, 2002

Quota International, Sertoma International, Lion's Club and Optimists Clubs.[19]

There are organizations that offer resources specifically to children in Maine. Listed below are the organizations and a brief description of the eligibility requirements.[20]

The Miracle-Ear Children's Foundation provides new or reconditioned "Miracle-Ear" hearing aids to families with children ages 16 and younger with an income level that does not allow them to receive public support.

The Dorothy Ames Trust Fund provides assistance to deaf children throughout New England. Among the services provided is the purchase of hearing aids. The eligibility is based on need and income.

Another organization is the Howard & Espa Michaud Charitable Trust which provides assistance to children in the Aroostook County area. The purchase of hearing aids is among the services provided. All other funding resources must be accessed first.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Most insurance companies do not provide coverage for hearing aids. There are over 1,000 types and models of hearing aid devices which include disposable, analog, analog programmable and digital programmable models.

There are four basic styles of hearing aid devices: In-the-Ear, Behind-the-Ear, Canal Aids which include In-the-Canal and Completely-in-Canal, and Body Aids. The style of hearing aids depends upon the age and extent of hearing loss in the individual. For example, the Canal Aids and In-the-Ear aids are not typically recommended for children. Body Aids are usually used by people with profound hearing loss.

Most of the devices mentioned above can use any of the technology available. The analog technology, the least expensive, provides the least amount of

[19] SHHH website, "Financial Assistance for Hearing Aids and Personal Assistive Technology", www.shhh.org

flexibility for the audiologist. They are able to make some adjustments, however the device was built to various specifications initially determined by the audiologist. The analog programmable model will accommodate more adjustments than the analog technology. In some cases the device can be equipped with a remote control so the wearer can change the setting according to a given listening environment. The digital programmable model is typically the most expensive. The device is programmed with a computer and can adjust the sound quality and response time on an individual basis.

The cost of these models can vary from $400 to $7,200.[21] The extent of the financial hardship of hearing aids is related to the type of model purchased. Since the expected life on these devices is 3 to 5 years, the cost of the hearing aids can become a financial hardship depending upon the model purchased. The Maine median family income for 2001 was $27,250,[22] therefore the percentage of income for the purchase of one hearing aid ranges from 1.5% to 26% depending upon the model of the hearing aids. The replacement rate also impacts the financial hardship.

For children with a hearing loss, the expected life of a hearing aid is even smaller since they need to be replaced as the child grows. Therefore, for families that have children with a hearing loss, the financial hardship can be greater.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

The percentage of Maine residents that are expected to utilize this mandated benefit is 0.69%. The corresponding annual expected percentage is 0.17%. Therefore the demand is quite small.

If LD 1087 were amended to cover children only, the demand is even smaller. Only 0.09% of Maine residents would be expected to utilize the benefits from this mandate in any given year.

[20] Maine DoD Resource Guide, Children's Hearing Aids, www.state.me.us/rehab/dod/child_haids.htm
[21] Insider Report: How to Buy Hearing Aids, www.earinfo.com/Rehab6.html
[22] Kaiser Family Foundation website, State Health Facts Online, Maine: Median Family Income, www.statehealthfacts.kff.org

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Several members of the public testified with regards to LD 1087. Five members who testified were in favor of the bill. No one appeared with opposing testimony and one member of the public appeared with neutral testimony. However, Anthem submitted written testimony in opposition of the bill.

Three of the individuals testifying were adults with hearing losses. All testified that the cost of the hearing aids were a financial hardship. They also addressed the social hardships faced by the hard of hearing and/or deaf community, including the difficulty of maintaining employment.

Another adult who testified classified himself as culturally deaf, or one who grows up with deafness. He testified to the social hardships for the hard of hearing and deaf communities and the need to support these individuals.

A representative for the Consumers for Affordable Healthcare testified in favor of LD 1087. She testified to the social difficulties for people affected by hearing loss. She stated that fiscal impact studies by other states concluded coverage would add minimal costs and the current health insurance benefits do not adequately meet the needs of those with hearing losses.

In addition, a representative from the Chamber of Commerce testified with a neutral testimony. The representative encouraged the committee to perform a study on the proposed mandate to determine the potential cost. The Chamber is concerned with the cost of health insurance and the affect additional benefits may have on that cost.

Anthem provided written testimony in opposition to LD 1087. Anthem estimates that the bill will add 1.5% to the cost of health insurance premiums. They believe the potential benefit to a few individuals must be weighed against the burden being born by employers and individuals struggling to maintain their health insurance coverage as the costs continue to rise.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by*

group plans.

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Currently, there are seven states that have enacted legislation for the coverage of hearing aid devices. Of those states only one, Kentucky, requires coverage for adults. Currently, there are no studies performed that determine if the mandated benefit enacted in Kentucky has met the needs of the hard of hearing and deaf communities.

Most of the states that have enacted legislation for the coverage of hearing aids have age limits and benefit limits. The most common age limit is age 18 and the most common benefit limit is $1,400 per hearing aid. In addition, there are usually limits as to the frequency of the purchase. While no evidence is available for the impact the legislation has had on the consumers' needs, a financial impact study was performed in Maryland. This study concluded the additional cost of adding the mandate would be 0.1% of premium. The Maryland mandate only covers children and limits the benefit to $1,400 per hearing aid.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

The Maine Newborn Hearing Program estimates that approximately 40 to 60 infants per year will be ultimately identified to have mild to profound hearing loss. Most likely, hearing aids will be recommended for these individuals.

11. *Alternatives to meeting the identified need.*

As previously discussed, the VR Program provides hearing aid devices to individuals who find their disability an impediment to employment. This program works in combination with the individual's private insurance to provide full coverage. At the present time, this program has a waiting list. This program could be expanded so that more individuals could be helped each year. This

alternative however, would not help those currently employed whose insurance coverage has significant limitations. In addition, this program is partially funded by the State of Maine and would require additional funding. Maine is currently experiencing a deficit; finding additional funds for would be difficult.

At the present time, MaineCare does not cover hearing aids for adults. The program could be expanded to provide hearing aid devices for adults. However, this would only impact those individuals who meet the eligibility requirements for MaineCare. It would not impact those hard of hearing individuals employed whose employer's health insurance does not provide coverage. This option would require additional funding by the State.

There are many charities that will help with the procurement of a hearing aid device. The Maine Division of Deafness website contains resources available for children's hearing aids. In addition, there are numerous organizations for the deaf and hard of hearing community that provide resource guides and services for the purchase of hearing aids. These organizations include, but are not limited to: Alexander Graham Bell Association for the Deaf and Hard of Hearing, Listen Up, National Institute on Deafness and Other Communication Diseases and SHHH.

The Maine Division of Deafness provides services to the deaf and hard of hearing residents. These services could be expanded to provide financial aid to the deaf and hard of hearing residents with the purchase of hearing aids. This alternative would not limit the access to only those individuals who find a barrier to employment like the VR program, to only those individuals who meet the financial eligibility requirements as MaineCare or the charities or to only those with health insurance as LD 1087 would require. However, expanding services to this division would require additional funding by the State.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The number of individuals with the need for hearing aids for which LD 1087 will apply is very small. We have estimated that only 0.69% of the Maine residents would be impacted by this mandate. While a significant portion of the population has hearing losses, a large percentage of those individuals are over

age 65 and most of these would not be impacted by this law. Most of these individuals are covered under Medicare and the supplemental insurance plans. Medicare and the traditional supplemental insurance plans do not cover hearing aids.

In addition, studies estimate that only 20% of all individuals who could benefit from a hearing aid actually use one. The corresponding statistic for children with hearing loss is much higher, over 60% of children with hearing loss use hearing aids.

The proposed benefit is not inconsistent with the role of insurance. Hearing aid devices could be classified similarly to other devices that help individuals function, such as eye glasses or durable medical equipment (DME). Eye glasses are typically covered under vision insurance and not health insurance and are usually limited by dollar amounts and frequency. DME benefits have been added to health insurance policies over the years, however, again it is typically on a limited basis.

The benefit is not inconsistent with managed care. The bill requires managed care organizations to provide these services, however no specific language in the bill forbids managed care organizations from requiring the use of preferred providers.

13. The impact of any social stigma attached to the benefit upon the market.

No other ailment is so widely accepted as just a part of living as is loss of hearing, especially as one ages. However, the acceptance is directly related to the age at which the hearing loss occurs. Hearing loss occurring at older ages is widely accepted as part of the aging process.

However, untreated hearing loss can have serious social and emotional consequences. A study conducted by the National Council of Aging shows that individuals aged 50 and older with untreated hearing loss are more likely to report depression, anxiety and paranoia and were less likely to participate in organized social activities than individuals who wear hearing aids. Individuals who wear hearing aids report improvements in their social lives and relationships with family and friends.

The survey, cited above, found several social stigmas associated with hearing aids that prevented individuals with hearing losses from using hearing aids. Approximately two-thirds of the non-users felt their hearing was not poor enough to warrant a hearing aid and felt they could get along without one. About 20% of the non-users believed it would make them feel old or others would perceive them as old.[23] In addition to the social issues described above, adults struggling without hearing aids can be forced to change jobs and may find it difficult to further their education and professional training.[24]

Hearing loss in children can have serious effects on the child's development. It is widely understood that hearing is critical for the development of speech, language, communication skills and learning. Treatment at young ages through the use of hearing aids can help children develop these skills and prevent social stigmas later in life.

14. The impact of this benefit upon the other benefits currently offered.

Currently, most health insurance policies in Maine do not provide coverage for hearing aids. These benefits would be subject to the annual and lifetime maximums contained within the policy, however it is likely it will have very little or no impact on the maximums. Therefore this benefit will have little if any impact on current benefits offered.

[23] National Council on Aging, "Untreated Hearing Loss Linked to Depression, Anxiety, Social Isolation in Seniors", May 1999
[24] Ideal Lives website, "Resources for People who can't afford hearing aids and cochlear implants" www.ideallives.com

If LD 1087 is amended to limit the amount of the benefit to $1,400 per hearing aid and only 2 hearing aids every 36 months, the benefit will have little if any impact on other benefits currently offered.

If LD 1087 is amended to only cover children, again there will be little if any impact on other benefits currently offered.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

It is not anticipated that the hearing aid mandated benefit alone would impact premiums sufficiently to cause employers to shift to self-insurance. In addition neither of the proposed amendments to LD 1087 would cause employers to switch to self-insurance. We do not know the percentage of self-insured plans that presently cover hearing aid benefits.

However, state legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 2002 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that over 50% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Anthem estimated that LD 1087 would add $7.92 per member per month to the State Employee Health Insurance Plan. This would be a 2.9% increase in the premium. If the benefits were limited to $1,400 per hearing aid and two hearing aids every 36 months, they estimated the impact to be $5.83 or 2.1% of premium. If the coverage was limited to children only, the cost would be $0.32 or 0.1% of premium.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

Mandating an unlimited maximum for payment of hearing aids would probably increase the cost of the hearing aids over the next five years. It is an accepted insurance maxim that the costs of services increase when there is a third-party payor funding the majority of the costs. This is consistent with the results of a Factiva study which shows that members who perceive a high need for health care will purchase the richest plan, resulting in a third-party funding the majority of the costs.[25]

The increase in costs would also be partially due to improved technology and demand for the best technology. In testimony given by Owen Loque, he stated that he felt guilty for spending additional money when purchasing the digital model. When a third-party payor begins to fund the costs of these devices, individuals are less likely to be concerned with the financial differences between the models and more likely to purchase the top-of-the-line models. In an informal survey conducted by the Listen Up organization, the organization found a high percentage of people with hearing loss are being forced to do with less than the optimal hearing aid for their needs due to cost considerations.

The amended language with the limited benefit of $1,400 per hearing aid will require purchasers to consider the financial aspect of the various models. If a top-of-the-line model was chosen, the purchaser would be paying a large majority of the cost for those devices. In the cases where the less expensive devices provide sufficient aid, individuals may be more likely to purchase these devices since their out of pocket expenses would be minimal.

[25] "Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis", by Michael Schoenbaum, Mark Spranca, Marc Elliott, Jay Bhattacharya, Pamela Farley, April 1, 2001, Inquiry, Volume 38, Issue 1

There is a belief that volume can force costs down. While there is a significant portion of the population that is impacted by hearing loss and could benefit from hearing aids, LD 1087 would not apply to the health insurance coverage for the majority of these individuals. Under current utilization, approximately 0.17% of the population would take advantage of the benefit in any given year. However, the insurance coverage of hearing aids is expected to increase the utilization; therefore, approximately 0.27% would be expected to utilize the benefits. Therefore, the law would not induce enough demand to force the costs of hearing aids down.

If the coverage would apply to children only, the mandate is only expected to help 0.09% of the Maine residents. Currently however, about 63% of those with a hearing loss use hearing aids. Anecdotal information given to the Maine Newborn Hearing Program shows families will often use credit cards, personal loans, home equity loans and other forms of financial assistance to purchase hearing aids for their children. Most functional families will often sacrifice whatever they can to provide for their child. Therefore, the demand from children is not likely to increase significantly.

2. *The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

Currently, only 20% of those with hearing impairments use hearing aid devices. There are many reasons that the hard of hearing do not use these devices. In many cases, the initial hearing aid is purchased, however due to discomfort it is placed in a drawer and not worn again. It is difficult to determine the magnitude of those who try a hearing aid but end up not using them. In an informal survey performed by the Listen Up organization, about 4% of those surveyed (adults and children) are doing without hearing aids due to the cost. There is the possibility more people with hearing impairments will take advantage of the insurance benefit and at least try the devices.

The potential increase in hearing aid use by children is even less. Over 60% of children with hearing impairments use hearing aids. Only 1% of children with hearing impairments are doing without hearing aids due to the cost. Therefore the number of new potential users who are children is relatively small.

The greatest potential for increase in the use of hearing aids is more frequent replacements. While there is no data to support the premise that many hearing aid users wait beyond the life of the hearing aid to purchase new devices, there is a large amount of anecdotal information. In testimony presented in favor of this bill, two individuals in Maine testified they delayed the purchase of hearing aids due to financial hardships. Another survey on insurance coverage and hearing aids, which collected and published responses, reported many instances where the purchase was delayed. The common theme in these statements suggests that hearing aids would be purchased earlier if they were covered by health insurance.

It is difficult to assess whether the potential increased use will be appropriate or inappropriate. In the extreme cases, the determination may be easier. Clearly, those cases where the hearing aid is purchased and then placed in a drawer is an inappropriate use of precious health care dollars. However, the case where the individual replaces hearing aids every two or three years when in the past they replaced them much less frequently is not cut and dry.

3. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

In the more severe cases of hearing loss and deafness for which hearing aid devices do not provide sufficient treatment, more people are trying cochlear implants as an alternative. However, this type of treatment is controversial and may not provide the results the patient anticipates. The treatment is usually reserved for the deaf in order to provide some sound information. Most successful cases are for adults who have gone deaf in their adult-life. It is anticipated that cochlear implants are not replacement treatments for the majority of individuals who benefit from hearing aids.

The procedure is extremely controversial when performed on children. The National Association of the Deaf is not in favor of cochlear implants for children. The procedure is invasive and has not been successful in producing the desired results of providing access to the spoken language. The procedure is very expensive and covered by most health insurance policies, unlike hearing aids.

At this time there are very specific requirements a person needs to be considered a candidate for cochlear implants. The hearing loss must be profound and

bilateral. Profound deafness is defined as a loss of 90 dB or more. In addition, they must be able to obtain sentence recognition scores of 30% correct or less under the best aided conditions.[26] While the criteria could change in the future as the technology advances, given the controversy surrounding the procedure and the mixed results, it is anticipated that this will not be an alternative treatment to hearing aids.

This mandate would probably result in more expensive treatment by providing higher payment for hearing aids. It is reasonable to expect that with an unlimited benefit, the more expensive types of hearing aids will be purchased.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

Insurance companies and HMOs may implement guidelines for the frequency of replacement and repairs that are consistent with the goals of the legislation. The insurance companies may set up guidelines where the severity of hearing loss may dictate the type of hearing aid that will be covered. For example, children with minimal hearing loss or unilateral hearing loss should be monitored closely for progression. Hearing aids and other assistive devices should be considered on a case-by-case basis.[27]

Insurance carriers could require prior authorization for hearing aids in the same manner as prior authorization is required for any other covered benefit. Managed care plans may require that hearing aid services be rendered by a provider who contracts with the carrier and that the hearing aid device is provided by a vendor designated by the carrier. By limiting the providers who are able to render services, the HMO may be able to negotiate better deals and reduce the cost for the health plan and the beneficiary.

Suggestions have been made to try to contain the additional financial burden for the health insurance policy. Most of the health insurance companies that responded to the Department's requests are concerned with the rising cost of health insurance. Incorporating additional mandated benefits to these policies, even if it appears small, only adds pressure to the health insurance crisis. Many

[26] Loizon, Phillip, "Introduction to cochlear implants", www.utdallas.edu
[27] American Journal of Audiology, "Amplification for Infants and Children With Hearing Loss", Vol. 5

companies recommended the mandate be dropped.

The companies did make suggestions for alternative language if the mandate is approved.

CIGNA suggested the limiting coverage to children under 21 and setting a dollar limit of $1,400 per hearing aid. They suggested limited coverage to one hearing aid every 2 years to accommodate the need for new hearing aids as children grow.

UHIC suggested the following:

> "We recommend that the proposed mandate be dropped altogether. We feel that it adds a significant cost to plans at a time when costs are already increasing at a very high rate. This mandate needlessly burdens insured plans, which include all small groups, with added costs, while not impacting large groups that can self-fund their plans. If some mandate is deemed to be necessary, we recommend that it be limited to one hearing aid every other year, with a maximum $1,000 eligible allowed cost (not net benefit) per aid. This would reduce the cost increased from the proposed "unlimited" mandated level by approximately 2/3. The cost increase due to this reduced mandate would be approximately 0.4% of the total cost of either plan."

Harvard Pilgrim does not support the legislation. If a mandate is required, they recommend it be limited to a fixed number of hearing aids during a specified period of time and to a maximum dollar amount per hearing aid.

Anthem, in written testimony, stated their opposition to the bill, citing the additional costs it would add to small group health insurance premiums. They did not offer any suggested alternative language.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

There are a significant number of people who are affected by hearing loss and could benefit from hearing aid devices. However, a significant portion of them are over the age of 65 and are covered under the Medicare program. The

proposed bill would not have an impact on the majority of these individuals. It would only impact those covered as an employee or retiree under an employer's group plan. The number of individuals who have coverage subject to the proposed mandate and who are expected to utilize services in any year is 0.27% of Maine residents. If the bill is amended to cover only children, only 0.09% of residents are expected to receive benefits annually. Therefore it is expected that this bill will not have an impact on the number of providers for these services.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

We have developed a range of costs for the three potential benefits of the proposed bill. The traditional actuarial approach calls for an incidence rate, an average cost, and an estimate for expenses. Our estimates are summarized below and detailed in Appendix D.

Unlimited Benefits

We have estimated that the frequency of hearing aid usage in the insured population is 0.5% per year. We have a cost range of $400 to $7,200 depending upon the type of hearing aid chosen. Claims information provided by CIGNA shows the average cost of hearing aid devices is about $3,000. Assuming the average cost-sharing amount is 80%, the expected cost of the benefit to the insurance company is $2,400. These statistics generate a $1.64 PMPM claims cost. Assuming the average expense load is 12%, the gross cost of adding hearing aids would be $1.86 PMPM or 0.7% of premium. This assumes no increase in costs or utilization over what is currently experienced. However, it is well documented that when a third-party payor is introduced, costs and utilization increase.

If we assume the replacement rate of hearing aids increases from an average of every 4 years to an average of every 2.5 years, the incidence rate increases to 0.8% per year. If we assume the costs increase to an average cost of $5,000 prior to cost sharing since more individuals are able to purchase higher-end models, the gross cost of adding hearing aids would be $3.10 PMPM or about 1.2% of premium.

Benefits Limited to $1,400 and 2 Hearing Aids Every 36 Months

We expect the limit on the replacement rate for hearing aids to 2 hearing aids every 36 months to have a small impact on the incidence rate since the lifespan of hearing aids is expected to be 3 to 5 years. Children will be impacted since their replacement rates are higher than adults. We have assumed an annual incidence rate of 0.7%. The benefit is limited to $1,400, therefore the expected increase on claims is $0.80 PMPM or on a gross basis $0.90 PMPM. This represents about 0.3% of premium.

Benefits Limited to Children Only

With this amendment, the bill proposes only to cover hearing aids for persons under age 21. We have estimated the annual frequency to be 0.3% of Maine insured residents. Inherent in this number is the assumption that hearing aids will be replaced on average every other year. If the average cost of a hearing aid for children is $5,000, the expected increase in claims is $0.95 PMPM. On a gross basis the increase in premium is $1.08 PMPM or 0.4% of premium.

Both Amendments

If both amendments are adopted, the result is an even lower impact on the insurance premiums. The estimated annual frequency is expected to be 0.2% and the expected average cost is expected to be $1,400. Therefore the increase in gross premium is expected to be $0.25 PMPM or 0.1% of premium.

Other Estimates

As stated earlier, Maryland analyzed the impact of the hearing aid benefit. The benefits in the Maryland mandate only cover children and were limited to $1,400 per hearing aid and a limit of 2 hearing aids every 36 months. The study estimated the increase in premium rates to be about 0.1%.

Anthem currently does not provide coverage for hearing aids. According to Anthem, unlimited hearing aid coverage is expected to increase premiums by 3.9% for the Individual plans and 1.5% for the small group plans. If coverage is limited to $1,400 per hearing aid with a limit of 2 hearing aids every 36 months, the increase in premiums is expected to be 2.9% and 1.1% for individual policies and small group policies, respectively. If coverage is limited to children only, the expected increases in premiums are 0.2% and 0.1% for individual and small groups, respectively. In Anthem's calculation, they assumed a higher percentage

of individuals who use hearing aids than our calculation.

CIGNA currently does not cover hearing aids. They estimate the following increases in costs:

$PMPM requirements

PMPM Impact	Large Group HMO	Large Group PPO/Indemnity	Small Group HMO	Individual HMO
Premium	$0.98	$0.61	$1.16	$2.01
Administration	0.08	0.03	0.18	0.31
Premium, limiting costs and frequency	0.49	0.30	0.58	1.00
Admin, limiting cost and frequency	0.04	0.02	0.09	0.16
Premium, children covered	0.32	0.10	0.38	0.66
Admin, children covered	0.03	0.01	0.06	0.10

% of Premium

PMPM Impact	Large Group HMO	Large Group PPO/Indemnity	Small Group HMO	Individual HMO
Premium	0.30%	0.19%	0.32%	0.27%
Administration	0.02	0.01	0.05	0.04
Premium, limiting cost and frequency	0.15	0.09	0.16	0.14
Admin, limiting cost and frequency	0.01	0.00	0.02	0.02
Premium, children only	0.10	0.06	0.11	0.09
Admin, children only	0.01	0.00	0.02	0.01

UHIC provided the following cost estimates:

UHIC Estimate Premium Difference Due to Proposed Mandate		
	Unlimited Benefit	
Current Plan Benefits	**PMPM**	**Percent of Total Plan Claims**
$250 deductible, 10% coinsurance,		

$2,000 OOPL	$2.38	1.1%
$500 deductible, 20% coinsurance, $2,500 OOPL	$1.90	1.0%

If a $1,400 maximum per hearing aid with a limit of 2 hearing aids every 36 months were approved, UHIC estimates the resulting increases would be 0.6% and 0.5% for the plans described in the table above.

If coverage were limited to children only, they estimated the increase to both plans listed above to be 0.7%.

Fortis Insurance Company and John Alden Life Insurance Company do not cover hearing aids currently. They did not provide any cost impacts for the mandate.

Harvard Pilgrim estimates the cost of the unlimited benefit to be in the range of 0.5% to 1.0% of premium. If the bill is amended to limit the benefit to $1,400 per hearing aids and 2 year hearing aids every 36 months, they estimate the increase in premiums to be 0.2% to 0.3%. If only children are covered, the increase is estimated to be 0.1%.

Aetna did not provide a direct premium increase amount but estimated that the impact of this mandate with $1,400 limited coverage could be 1% of the single premium rate.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would be no additional increase in cost beyond premiums and administrative costs. There may be some reduction in indirect costs. Proponents argue that untreated hearing loss can cost millions of dollars for society in lost productivity and education. The Better Hearing Institute has estimated the annual costs due to lost productivity, special education and medical care as a result of untreated hearing loss to be $56 billion per year.[28]

Studies have shown that children identified with hearing loss who begin services

[28] Hear It website, www.hear-it.org

before 6 months old develop language on par with their hearing peers.[29] The Hearing Loss Organization estimated the cost associated with special education when early intervention and treatment is not received is $420,000 and has a lifetime cost of $1 million per individual.[30]

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

The impact to the total cost of health care is expected to be negligible. The main purpose of the legislation is to increase the affordability of hearing aids for Maine residents. Infant screening tests are already required in Maine; therefore, the issue of the diagnosis of hearing problems at an early age has already been addressed. This legislation is not expected to change the diagnosis patterns. As such, there will be some people who will purchase hearing aids in the future since the mandate has made the hearing aids more affordable. However, based on an informal survey, only 4% of the hard of hearing do not purchase hearing aids due to the costs associated. With the incorporation of the insurance mechanism in the hearing aid purchase, it is expected the frequency of the purchases of hearing aids will increase as well as the type of hearing aid purchased. These items would be expected to have a small effect on the cost of insurance, about 1% at the most, and therefore would have an even smaller impact on the total health care dollar.

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

The impact for any particular group would depend upon its current benefit. Small groups and individuals would see an increase of about 1.1%, because typically these groups do not provide retiree health coverage. Large groups

[29] American Speech Language Hearing Association website, "Children and Hearing Aids"
[30] Hearing Loss Organization website, "Hearing Loss Fact Sheets"

would see an increase similar to that of the overall population of 1.3% since they would more than likely provide retiree health benefits. CIGNA estimates that the cost for large groups would be lower than the cost for small groups and individuals on a PMPM basis. However, the costs as a percentage of premium are similar for all groups; the differences are not material.

Insurers in Maine estimated this mandate with unlimited benefits would cost between 0.2% and 3.9%. We estimated the cost impact to be 1.2% in aggregate.

In the proposed amendment with the limited dollar amount and time period, the Maine insurers estimated the impact of the bill to be between 0.2% and 2.9%. We estimated the impact to be 0.3%.

If coverage is limited to children only, the insurers estimates ranged from 0.06% to 0.7%. We estimated the costs to increase by 0.4%.

10. *The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.*

If the costs of some hearing aid devices that are not currently covered by insurance are being paid in part or total by public funds, then there would be a shift from public to private. MaineCare only provides coverage to individuals under age 21. Information with regards to the amount of hearing aids provided through MaineCare was not available in time to include in this report. It is possible that some of this would be transferred to the private sector, however the total amount of cost shifting is expected to be minimal.

In addition, the VR program authorized funding for about 300 hearing aid devices on average in each of the last two fiscal years at $501,821 for 2002 and $485,916 for 2003. Typically, recipients of VR funding are individuals whose disability has created a barrier to employment. Funding is part Federal and part State monies. While some of these hearing aid devices may shift to the private sector, we do not expect the shift to be significant.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

A survey performed by the National Council on Aging found that adults (aged 50 and over) who do not wear hearing aids were more likely to report depression, anxiety and paranoia, more so than seniors who wear hearing aids. In addition, it found that non-users of hearing aid devices were less likely to participate in social activities. This could be a contributing factor to the depression, anxiety and paranoia reported.

The benefits of using hearing aids reported in this survey ranged from improved relationships at home and a sense of independence to their social life and their sex life. The survey also questioned family members who also reported improvements with hearing aid use.[31]

While the survey was for adults aged 50 and over, the results can be extended to adults of all ages. The hard of hearing adults feel isolated; many complain they do not feel that they are a part of the hearing community or the deaf community. Hearing aids would greatly affect their ability to become a part of the hearing community.

The hard of hearing also find it difficult to obtain or maintain employment. The more severe the hearing loss, the more difficult employment can be. Hearing aids have the potential to help these individuals with employment. Being a productive member of society, with the ability to communicate with one's peers may help these individuals fight the feelings of depression, anxiety and social isolation.

[31] National Council on Aging

The percentage of the hard of hearing that actually use hearing devices is small, only in the range of 20%. In some cases, hearing aids are purchased, but for a variety of reasons are placed in a drawer and not used. Some of the more common reasons are discomfort, squealing or whistling due to improper fit, the volume of noises, background noise and a misconception of the results of hearing aids. Hearing aids do not restore normal hearing nor do they eliminate background noise. Adjusting to the use of hearing aids is a gradual process that requires learning to listen in a variety of environments and becoming accustomed to hearing different sounds.

For both children and adults, a four-stage program is recommended. The stages are assessment, selection, verification and validation. As stated above, the successful use of hearing aid devices takes time and patience.

In the case of children with hearing loss, it is widely recognized that hearing is essential in the development of speech, language, communication skills and learning. As such, the earlier treatment begins for hearing loss, the less serious the ultimate effects. Studies have shown that for children who are identified and receive hearing services starting before 6 months of age display no discernable differences in their development of language, whether it is spoken or signed, than their hearing peers.[32] When language skills are compared for children who began hearing services after 6 months of age to those who started by 6 months of age, those who started by 6 months of age demonstrated significantly better language scores.[33]

In general, children with mild to moderate hearing loss (16 to 55 dB HL) will usually benefit from the use of hearing aid devices, speech reading and extra help from speech and language professionals. Children with moderately severe to profound hearing loss may require more early intervention. Hearing aids or cochlear implants are often recommended, depending on the severity of the loss.

Hearing loss does not affect a child's intellectual ability however it can make learning very difficult for that child. Children who are hard of hearing will have

[32] National Information Center for Children and Youth Disabilities, "Deafness and Hearing Loss"
[33] Language of Early- and Later-identified Children With Hearing Loss

more difficulty learning vocabulary, grammar, word order and verbal communication. The typical consequences of hearing loss include delays in language development and academic achievement. Hard of hearing children's academic achievement is below that of their hearing peers with average reading scores for high school graduates at the fifth-grade level. These types of reading limitations have a pervasive, negative impact on overall academic achievement.[34] Special education services are required in order for these children to receive an adequate education. Special services may include regular speech, language, and auditory training from a specialist, amplification systems, services of an interpreter for those who sign, favorable seating, captioned videos, assistance of a notetaker, instructions for teachers and peers in alternative communications and counseling.[35]

The US Preventive Services Task Force in 2001 recognized the benefit to early hearing detection *and* intervention. The task force stated there is a preponderance of anecdotal evidence and clinical research which indicates the early detection and intervention provides substantial benefits, however additional outcome studies and clinical trial are needed.[36] In addition to hearing aid devices, counseling, parent education and rehabilitative services are necessary for a successful outcome.[37]

Untreated hearing loss can result in millions of dollars in lost productivity and special education costs. The Better Hearing Institute estimated annual costs in the United States due to lost productivity, special education and medical care to be in the range of $56 billion. In the case of children that do not receive early intervention, special education can cost schools an additional $420,000 with a lifetime cost of $1 million per individual.

For those individuals that try hearing aids but do not use them, the purchase is a waste of health care resources. Time and patience is required in the successful use of hearing aid devices. For the individuals, both adults and children, that do

[34] Language of Early- and Later-identified Children With Hearing Loss
[35] National Information Center for Children and Youth Disabilities
[36] Hearing Loss Organization website
[37] American Journal of Audiology

take advantage of the availability of hearing aids and use them, their quality of life can improve significantly.

2. *If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

      This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

   b. *The methods of the appropriate professional organization that assure clinical proficiency.*

      This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

The costs of hearing aids range from $400 to $7,200 depending upon the style and technology purchased. Currently the average cost of a hearing aid is approximately $3,000. The personal income per capita in 2001 in Maine is $27,250. The cost of the average hearing aid is 11% of the personal income per capita. Purchasing a more sophisticated hearing aid is over 25% of the personal income per capita if they must fund most or all of the entire cost.

If the limit of $1,400 per hearing aid device amendment is approved, the average current out-of-pocket cost for Maine residents would be $1,600. This would be about 6% of the personal income per capita. The more sophisticated version of the hearing aids would require approximately $5,800 in out-of-pocket expenses or over 20% of the personal income per capita.

2. The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.

If this benefit is to be provided as a mandatory offer as opposed to a mandatory benefit, then the costs would be considerably higher because only those who perceive a need will purchase the coverage.

3. The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies. The Bureau's estimates of the maximum premium increases due to existing mandates and the

proposed mandate are displayed in Table A.

TABLE A – MAXIMUM PREMIUM INCREASES			
	Group (more than 20 employees)	**Group (20 or fewer employees)**	**Individuals**
Current Mandates			
Fee-for-Service Plans	10.29%	4.18%	3.32%
Managed Care Plans	9.09%	4.55%	3.24%
LD 1087 – Unlimited			
Fee-for-Service Plans	1.3%	1.1%	1.1%
Managed Care Plans	1.3%	1.1%	1.1%
Cumulative Impact			
Fee-for-Service Plans	11.72%	5.33%	4.46%
Managed Care Plans	10.51%	5.70%	4.38%

Table A requires the analysis to be performed on large group insurance, small group insurance and individual insurance. In our analysis we incorporated those individuals over age 65 who have group health insurance through an employer, since these policies would have to provide benefits required under LD 1087. Individual Medicare supplement insurance policies are not subject to LD 1087. Typically, only large employer groups provide their retirees with health insurance. Therefore, the large group insurance (those with more than 20 employees) analysis contains the impact of those retirees with health insurance. The small group insurance (those with 20 employees or less) and the individual insurance analysis does not take retirees into account.

If either amendment is passed, the cumulative impact would be less.

The estimated cost of current mandates is detailed in Appendix B. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. However, four of the most costly mandates – mental health, substance abuse, chiropractic, and screening mammograms – were enacted before cost estimates were required. These four statutes require carriers to report annually the amount of claims paid for these benefits. Our estimates are based on these reports. However, the true cost impact of these four mandates is less than this for two reasons:

1. Some of these services would likely be provided and reimbursed even in the absence of a mandate.

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. However, a recent General Accounting Office (GAO) report[38] gives some indication of the magnitude of the reduction. The GAO report used the terms "total cost" and "marginal cost" in discussing item (1) above. The total cost is the cost of the benefits that are mandated. The marginal cost is the difference between this cost and that portion that would have been covered even without the mandate. The GAO report cited two studies that estimated the marginal cost:

- Maryland, which has more mandated benefits than any other state, found that the total costs of its mandates were about 15% of premiums, while the marginal costs were about 4.2%.[39]

- In a 2000 report, the Congressional Budget Office (CBO) concluded that the total cost of state mandates ranged from 5.4% to 22.0% of total claim costs while the marginal cost ranged from 0.28% to 1.15%.[40]

[38] General Accounting Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses", 2003
[39] Mercer Human Resource Consulting, "Mandated Health Insurance Services Evaluation, prepared at the request of the Maryland Health Care Commission", 2002
[40] Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts", 2000

VII. Appendices

Appendix A: Letter Requesting Study with Proposed Legislation

Appendix B: Cumulative Impact of Mandates

Following are the estimated costs for the existing mandates. The estimates for mental health, substance abuse, chiropractic, and screening mammography reflect the total cost of the benefits mandated. Estimates for other mandates reflect the impact of the mandate net of benefits that would have been covered even without the mandate.

- ***Mental Health*** (Enacted 1983) – The mandate applies only to groups of more than 20. Mental health parity for listed conditions was effective 7/1/96. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.27% in 2000, but held steady at 3.33% in 2001 and 2002. For 2001, this broke down as 3.22% for HMOs and 3.67% for indemnity plans. For 2002, this disparity increased to 2.72% for HMOs and 5.11% for indemnity plans. We assume an average of the 2001 and 2002 levels going forward, but add ¾ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31% and increased to 0.37% in 2001 and to 0.66% in 2002. The long-term decrease was probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 55% in 2001 but increased to 62% in 2002. The 0.66% for 2002 broke down as 0.62% for HMOs and 0.77% for indemnity plans. We estimate substance abuse benefits to remain at the current level, but add ¼ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to 1.51% in 2000. Since then, it decreased to 1.32% in 2001 and then increased to 1.45% in 2002. The level varies significantly between group and individual and between HMOs and indemnity plans. We estimate that going forward. The level will be continue at the 2002 level of 1.56% for group HMO plans, 1.31% for group indemnity plans, 0.35% for individual HMO plans, and 0.46% for individual indemnity plans. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.59% in 2001, which may reflect increasing utilization of this service. 2002 figures are not comparable to earlier years because one major company erroneously included Medicare supplement business in previous reports. The 2002 figure of 0.7% is therefore more accurate. This figure broke down as 0.72% for group HMO plans, 0.65% for group indemnity plans, .43% for individual HMO plans, and 0.73% for individual indemnity plans. The individual HMO data is not credible and the other variations are insignificant. We estimate the 0.70% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates

coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for smaller groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated to measurable cost impact for coverage of LCPCs.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	0[1]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[1]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20	1.02%	0.87%
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	5.14%	3.72%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.31%	1.56%
		Individual	0.46%	0.35%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.7%	0.7%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives.**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants.**	All Contracts	0[41]	0
2000	Access to **clinical trials.**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs.**	All Managed Care Contracts	0	0

[1] This has become a standard benefit that would be included regardless of the mandate.

2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care.**	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg.	Groups >20	.03%	.03%
		All other	.08%	.08%
2003	Coverage of **licensed clinical professional counselors.**	All Contracts	0	0
Total cost for groups larger than 20:			**10.29%**	**9.09%**
Total cost for groups of 20 or fewer:			**4.18%**	**4.55%**
Total cost for individual contracts:			**3.32%**	**3.24%**

Appendix C: References

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Appendix D: LD 1087 Benefit Cost Estimates

Estimate of Impact on Premium
Unlimited Benefits

1. Number of Hard of Hearing Residents in Maine under the age of 65 with Commerical Insurance		35,154
2. Number of Hard of Hearing Residents in Maine over age 65 with Group Insurance		9,324
3. Number of Hard of Hearing Residents in Maine with Commerical Insurance ((1)+(2))		44,478
4. Percent of Hard of Hearing that Use Hearing Aids		20%
5. Total Number of Hard of Hearing Residents that Use Hearing Aids ((3)x(4))		8,896
6. Average Number of Years for Expected Lifespan of Hearing Aids		2.5
7. Average Annual Hearing Aid Users		3,558
8. Average Insured Resident Affected by Legislation (includes 386,000 fully insured under age 65 retirees and 48,372 over age 65 with group health insurance)		434,372
9. Frequency of Users		0.8%
10. Average Cost per Hearing Aid	$	5,000
11. Average Cost after benefits (80%)	$	4,000
12. Average Cost Per Member Per Month	$	2.73
13. Average Gross Cost Per Member Per Month	$	3.10
14. Average Premium in Maine	$	259.08
15. Percent of Premium		1.2%

Estimate of Impact on Premium
Limited Benefit of $1,400 and 2 Hearing Aids Every 36 Months

1. Number of Hard of Hearing Residents in Maine under the age of 65 with Commerical Insurance		35,154
2. Number of Hard of Hearing Residents in Maine over age 65 with Group Insurance		9,324
3. Number of Hard of Hearing Residents in Maine with Commerical Insurance ((1)+(2))		44,478
4. Percent of Hard of Hearing that Use Hearing Aids		20%
5. Total Number of Hard of Hearing Residents that Use Hearing Aids ((3)x(4))		8,896
6. Average Number of Years for Expected Lifespan of Hearing Aids		3
7. Average Annual Hearing Aid Users		2,965
8. Average Insured Resident Affected by Legislation (includes 386,000 fully insured under age 65 retirees and 48,372 over age 65 with group health insurance)		434,372
9. Frequency of Users		0.7%
10. Average Cost per Hearing Aid	$	5,000
11. Average Cost after benefits (80%) maximum of $1,400	$	1,400
12. Average Cost Per Member Per Month	$	0.80
13. Average Gross Cost Per Member Per Month	$	0.90
14. Average Premium in Maine	$	259.08
15. Percent of Premium		0.3%

Estimate of Impact on Premium
Children Only

1. Number of Hard of Hearing Residents in Maine under the age of 65 with Commerical Insurance		3,509
2. Number of Hard of Hearing Residents in Maine over age 65 with Group Insurance		-
3. Number of Hard of Hearing Residents in Maine with Commerical Insurance ((1)+(2))		3,509
4. Percent of Hard of Hearing that Use Hearing Aids		62.8%
5. Total Number of Hard of Hearing Residents that Use Hearing Aids ((3)x(4))		2,204
6. Average Number of Years for Expected Lifespan of Hearing Aids		2
7. Average Annual Hearing Aid Users		1,102
8. Average Insured Resident Affected by Legislation		386,000
9. Frequency of Users		0.3%
10. Average Cost per Hearing Aid	$	5,000
11. Average Cost after benefits (80%)	$	4,000
12. Average Cost Per Member Per Month	$	0.95
13. Average Gross Cost Per Member Per Month	$	1.08
14. Average Premium in Maine	$	259.08
15. Percent of Premium		0.4%

Estimate of Impact on Premium
Children Only and Limited Benefit of $1,400 and 2 Hearing Aids Every 36 Months

1. Number of Hard of Hearing Residents in Maine under the age of 65 with Commerical Insurance		3,509
2. Number of Hard of Hearing Residents in Maine over age 65 with Group Insurance		-
3. Number of Hard of Hearing Residents in Maine with Commerical Insurance ((1)+(2))		3,509
4. Percent of Hard of Hearing that Use Hearing Aids		62.8%
5. Total Number of Hard of Hearing Residents that Use Hearing Aids ((3)x(4))		2,204
6. Average Number of Years for Expected Lifespan of Hearing Aids		3
7. Average Annual Hearing Aid Users		735
8. Average Insured Resident Affected by Legislation		386,000
9. Frequency of Users		0.2%
10. Average Cost per Hearing Aid	$	5,000
11. Average Cost after benefits maximum of $1,400	$	1,400
12. Average Cost Per Member Per Month	$	0.22
13. Average Gross Cost Per Member Per Month	$	0.25
14. Average Premium in Maine	$	259.08
15. Percent of Premium		0.1%